



Referral Number:	
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Healthy Homes Referral Form - Gloucester & District Citizens Advice

To refer to Gloucester & District Citizens Advice please complete the following section and ask the client to sign the Data Consent form below.

Client Details:		
Title: Mr / Mrs / Miss / Ms / Other (please specify)		
First Name:	Last Name:	
Partners Name (if applicable)		
Date of Birth:	Gender: Male <input type="checkbox"/>	Female <input type="checkbox"/> Transgender <input type="checkbox"/>
Contact Telephone Number	Ok to Call?	Can a message be left?
Mobile:	Yes / No	Yes / No
Home:	Yes / No	Yes / No
Address:		
Postcode:	Okay to send a Letter? Yes / No	
Email address:	Okay to send an Email? Yes / No	
Please provide a brief outline of the issue for which support is needed:		
Please provide a brief outline of the client's health issues:		
Referrers Details		
Name:	Contact Number:	
Organisation:		

Gloucester & District Citizens Advice need your permission to record personal and sensitive details about you and your referral. To comply with the Data Protection Act (1998) we must tell you how we use this data and ask for your permission. The record of your referral will be stored in a shared electronic case management system accessed by members of the CAB service. We will also be contacting you to arrange an appointment. By signing this form you are providing your permission for us to process your data in this way.

I give permission for Gloucester & District CAB to record and store my personal and sensitive information and to contact me again if necessary to follow up any outcomes achieved as a result of receiving advice

Client's Signature(s)..... **Date**

If the client is not present, please sign to confirm verbal consent given for referral.

Signed (Referrer)

For Office Use

Tick if verbal consent has been given over the phone.

Date